Care Integration and Payment Reform Work Group Recommendations

July 10, 2012 Draft

Goal

Apply a set of complementary strategies that will advance payment reform, care integration and consumer activation and responsibility, all in order to:

1. improve population health as assessed using indicators of function, quality of life and wellbeing[1], and
2. generate a reduction in the growth of global health care spending[2] such that spending slows over a three-year period until it is annually growing at no greater than the rate of inflation[3].

Strategies

1. **Advance Total Cost of Care contracting by public and commercial payers with accountable care organizations** (**ACOs**) over three years. Accountable care organizations shall integrate preventive, acute, post-acute, and chronic illness services (including behavioral health services). Beginning in FY14, ACOs shall also begin to integrate with local public health and social services agencies. In addition, specifically for Medicaid beneficiaries, beginning in FY14 and phasing in over three years, ACOs shall also integrate long-term care services[4] and integrate Medicare funding for those dually eligible for Medicaid and Medicare.

   An ACO is defined for this purpose as an organization of health care providers that assumes responsibility for the health and health care for a population of patients, including the cost and quality related to such care. An ACO can take many organizational and corporate forms, but minimally is comprised of a group of primary care clinicians working with a network of hospitals, physicians, and other health care professionals. It can also be defined to be comprised of primary care clinicians and any other providers. Provider market consolidation is not an objective for ACOs, but ACO formation may potentially further consolidate the provider market.

   Support advancement in ACO formation and contracting through the following actions:

   a. Set annual performance targets for Minnesota Health Care Programs, SEGIP and licensed commercial insurers to advance ACO contracting over three years and achieve the goal of reduced cost growth and improved population health status.

[1] See Strategy #3 for the recommended approach for assessment of population health.
[2] Defined for the purposes of this document as the allowable PMPM costs incurred and separately measured for the commercial, Medicare and Medicaid-covered populations.
[3] All Urban Consumers All Items less Food and Energy
[4] Long-term care integration would also benefit privately funded users of long-term care services.

i. the percentage of the payer's population covered under such arrangements;

	SFY14	SFY15	SFY16
commercial	TBD%	TBD%	TBD%
MN Health Care Programs	TBD%	TBD%	TBD%
SEGIP	TBD%	TBD%	TBD%

ii. transition from ACO Total Cost of Care shared savings arrangements (i.e., provider upside risk only) to Total Cost of Care shared risk arrangements (i.e., provider upside and downside risk) for payer/provider dyads of sufficient population size for sharing risk over three years, as jointly negotiated by payer and provider.

	SFY14 % shared risk	SFY15 % shared risk	SFY16 % shared risk
commercial	TBD%	TBD%	TBD%
MN Health Care Programs	TBD%	TBD%	TBD%
SEGIP	TBD%	TBD%	TBD%

iii. annual improvement in population health (i.e., the health status of Minnesotans) and health care (i.e., the health services provided to Minnesotans) for ACO enrollees, to be defined using a set of evidence-based measures identified by MDH with input from providers, consumers, employers, health plans, DHS and SEGIP. There should be separate targets for commercial/SEGIP and Minnesota Health Program populations, in recognition of the different starting points, but with a goal of disparity reduction;

iv. maximum annual change in medical expense (i.e., the medical cost trend) for the ACO covered population;

	SFY14	SFY15	SFY16
Commercial, MN Health Care Programs and SEGIP	CPI +2%	CPI +1%	CPI

b. DHS and SEGIP shall take necessary steps to meet the targets. The Department of Commerce shall consider options for ensuring commercial carrier compliance with the targets such as linking Qualified Health Plan eligibility in the insurance exchange to meeting the targets defined above in #1.a.i-iv.

c. MDH shall annually assess the performance of commercial insurers, DHS and SEGIP relative to targets i. through iv. defined in Strategy #1a. MDH shall utilize its existing authority (MN Statute 62J.301) to conduct the analysis or the legislature should provide new statutory authority for collecting and using data, if necessary. For the

future, the legislature should expand MDH's permitted use of the All-Payer Claims Database to support this annual assessment.

d. SEGIP shall convene large self-insured employer purchasers to present and discuss the potential benefits to the employers of Total Cost of Care payment arrangements with ACO, the benefits of aligning performance incentives across markets and what employers can do to advance use of such payment arrangements.

2. **Develop a limited set of common standards for how ACOs** should be structured and operate following a joint DHS-MDH-facilitated planning process, involving SEGIP, provider, health plan, consumer and employer representatives. These standards should be in addition to the measurement and reporting requirements defined in Strategy 3a. The planning group should recommend whether there should be a registration or licensure process for ACOs. Potential standards for consideration may include: core set of services, primary care/behavioral health[5] integration, integration with public health and social services, risk adjustment of payments including for the very highest risk patients, board composition and financial stability. The standards should not unduly limit ACO opportunity to experiment, innovate and compete.

3. **Implement a process for comprehensive performance measurement and public reporting of individual ACOs and their participating providers** to inform consumers and to assess ACO and carrier performance, and **evaluate health care homes and community health teams**.

   a. Drawing from the Statewide Quality Measurement and Reporting System (SQRMS), the CMS ACO quality measures, and performance measures utilized by DHS, direct MDH to coordinate with one or more existing community measurement entities to define a core measure set for ACO reporting for the array of populations to be served by ACOs. Pursue a core measurement set to address the risk of insurers sending different messages to the provider marketplace. The measure set shall include measures of access, patient engagement and experience, function, quality of life, well-being, provider/practice team satisfaction, clinical quality, utilization and health disparities, with methods for risk adjustment and patient attribution to the responsible ACO. In addition, the measurement set should anticipate the need for new measures that address the planned integration of long-term care, public health and social services.

   b. MDH shall define a measure set for ACO public reporting of Total Cost of Care using its Provider Peer Grouping methodology with methods for risk adjustment and patient attribution to the responsible ACO. In addition, the measure set should anticipate the need for new Total Cost of Care measures that address the planned integration of public health and social services. The measurement set does not preclude payers from using distinct methodology for calculating Total Cost of Care for contract purposes.

[5] Treatment of mental health conditions and for chemical dependency.

c. Commercial insurers shall collect and report the ACO core measure set and ACO Total Cost of Care, including for SEGIP, to MDH or its designee to i) avoid conflicting insurer requirements of ACOs and ii) for analysis. DHS shall similarly collect the ACO core measure set for Minnesota Health Care Programs and report it to MDH or its designee.

d. MDH or its designee shall make ACO and participating provider performance transparent to consumers, and the performance of ACO providers shall be compared to that of non-ACO providers. In addition, require distribution of such information through insurers and through the Exchange in a manner that will inform ACO and provider selection.

e. MDH shall contract for a robust evaluation of a) transformation of certified health care homes in Minnesota that assesses the health care homes and their potential to serve as foundational element of ACO development, and b) population-based community care teams capable of partnering with accountable care organizations to address psycho-social, public health, economic and referral needs. The evaluation should build upon the HealthPartners AHRQ TransforMN evaluation of the early experience of 134 health homes that is due to be completed in the fall of 2012 and evaluate experience between 2012 and 2015.

4. Because certain providers face special challenges when seeking to transform themselves to operate as health care homes, as ACOs and within ACOs, MDH, in consultation with DHS and SEGIP, shall **provide evidence-based technical assistance to FQHCs, small primary care practices, rural providers and providers specializing in care of populations with complex needs to help these providers succeed within a system in which ACOs are contracting for the Total Cost of Care**.

   a. MDH shall provide and contract for practice facilitators to provide time-limited support for the transformation of FQHC and small and rural primary care practices during SFY14 and SFY15 to become health care homes and/or ACOs, including but not limited to:

      i. use of the existing Department of Primary Care and Rural Health, the Area Health Education Centers (AHECs) and the University Office of Practice-Based Facilitators through the Department of Family Medicine;

      ii. contracted practice facilitators in the four urban and rural AHEC regions;

      iii. technical and financial assistance to clinics to apply and support time for practice improvement, and

      iv. a structure for dissemination of practice innovations informed by the lessons learned through the MDH/ICSI Health Care Home Statewide Learning Collaborative.

   b. MDH shall facilitate efforts of interested small, independent providers during SFY14 to create regional collaboratives for the purpose of delivering accountable care.

Assistance shall be available to existing networks[6] that could potentially serve as a central services entity for ACOs comprised of their members.

c. MDH shall facilitate discussions among interested payers and providers regarding the development of multi-payer ACO arrangements to aggregate payer population segments into a larger risk pool in order to support expanded Total Cost of Care contracting with ACOs where it would not otherwise be tenable.

5. MDH shall **address barriers to clinically appropriate data sharing** between providers in different health care organizations to better meet the needs of patients.
   a. Conduct a rigorous analysis of perceived and actual barriers to data sharing, including between behavioral health and somatic health clinicians, and how these may hinder achieving the goals for ACOs. As part of this work:
      i. assess electronic health record adoption by behavioral health, long-term care and social service providers and whether and how to assist their ability to participate in a health information exchange;
      ii. assess whether and how to expand financial incentives for EHR adoption and use, and for exchange of health information, targeting resources to higher-need settings, and
      iii. identify necessary protections to ensure patient confidentiality.
   b. Continue to develop and implement health information exchange (HIE) governance and accountability standards for Minnesota, including a state shared HIE services collaborative and standards for secure sharing of patient data across settings and state lines.
      i. Identify the priority transactions needed to share information between settings and determine the associated business processes, standards and technical requirements for each of the priority transactions.
   c. Explore whether additional statutory or rule changes are necessary to facilitate secure exchange of patient information across settings or between medical, community and social service providers with appropriate patient protections.

6. **Facilitate improved integration of behavioral health[7] and primary care services** through a combination of strategies, including:
   a. DHS shall pilot a health home service delivery system under Section 2703 of the ACA to serve populations with Serious Mental Illness and complex co-occurring conditions and for children with autism during SFY13-14.

   b. DHS shall expand the use of Screening, Brief Intervention, and Referral to Treatment (SBIRT) for substance abuse services in primary care settings and emergency rooms.

[6] Examples include Integrity, Minnesota Rural Health Cooperative, Lac Qui Parle Health Network, Wilderness Health Care Coalition and the Minnesota Healthcare Network.

[7] Treatment of mental health conditions and for chemical dependency.

c. MDH shall incorporate behavioral health integration training into technical assistance provided through MDH/ICSI Health Care Home Statewide Learning Collaborative and other channels.

d. ___ shall support the location of primary care clinicians in community-based mental health centers by ____.

e. DHS shall design, pilot and evaluate a psychiatric consultation program for children during SFY14, with consideration in the evaluation for potential future expansion to adults.

7. **Enhance the market availability of health insurance products that foster consumer accountability for health behaviors and create incentives for consumers to use high value providers** who deliver and coordinate care that is of high quality and low cost.

   a. The Department of Commerce, in partnership with MDH, shall identify existing commercial insurance products that foster consumer accountability for health behaviors and create incentives for use of high-value providers, as well as any barriers to adoption of these products by employers and consumers.

   b. The Department of Commerce shall share its findings with licensed Minnesota commercial insurers to help them make their products more attractive to employers and employees and shall also use the information to inform the Exchange product strategy. The Department shall also i) recommend possible statutory action to advance such products should the Department of Commerce, in consultation with MDH, determine that such action is necessary to ensure the availability of such products to consumers, or ii) take regulatory action to advance such products should the Department of Commerce determine that such action is necessary.

   c. The Department of Commerce and SEGIP shall work with employers of all sizes to educate them about health insurance products that foster consumer accountability for health behaviors and create incentives for consumers to use high value providers, and about strategies for educating their employees about assuming responsibility and making wise choices.

8. **Pilot the concept of** "**communities for health**." These will be community-based and operated organizations that involve citizens to set measurable and measured community-based goals for improved population health, health care and cost management, and take specific steps to achieve those goals. Their aim will be to activate and make accountable citizens, employers and communities to reduce health care cost growth and improve population health.

   a. Beginning in SFY14, MDH shall select 10 diverse communities for health four-year pilots that are informed by the experience of existing related but more limited efforts, including Community Health Boards and the State Health Improvement Program (SHIP), as well as pilots in Olmsted and Dodge Counties.

b. Communities for health shall utilize state-funded technical assistance with existing MDH, ICSI, health plan, county health department and other data sources to develop and evaluate annual goals for population health improvement and cost growth, and to define and implement specific actions to be improve consumer health behaviors, public health activity and provider performance.

c. Communities for health shall be represented on ACO boards and collaborate with ACOs to ensure alignment between community goals and the goals and performance of the ACOs that serve the community.

d. MDH, in consultation, shall formally evaluate the effectiveness of the communities for health pilots.